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No. 01-1423

In The

Supreme Court of the United States

SPENCER WADDELL,

Petitioner,

v.

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF INFECTIOUS DISEASES SOCIETY OF AMERICA, HIV MEDICINE ASSOCIATION OF INFECTIOUS DISEASES SOCIETY OF AMERICA AND COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE* AND SUMMARY OF ARGUMENT[1]

This *amici curiae* brief in support of the petition for certiorari is submitted on behalf of the Infectious Diseases Society of America, the HIV Medicine Association of the Infectious Diseases Society of America, and the Council of State and Territorial Epidemiologists (the "*Amici*"). The brief is filed with the consent of the parties.[2]

Our nation faces pressing public health and disease prevention challenges, such as new and emerging infectious diseases, and the threat of bioterrorism. An effective response to these and other actual dangers to the public health requires a rational, scientific, and consistent approach to risk assessment in order to direct finite resources towards threats that are both real and preventable.

The decision of the Eleventh Circuit in this case, like several other recent decisions of the courts of appeals, holds that a theoretical risk of harm satisfies the "direct threat" defense provision of the Americans with Disabilities Act (ADA).[3] This "zero-risk" approach, even where

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *Amici* state that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *Amici* and their counsel made any monetary contribution to the preparation or submission of this brief.

[2] Letters of consent from the parties have been filed separately with the Clerk of Court.

[3] *Waddell v. Valley Forge Dental Associates, Inc.*, 276 F.3d 1275, 1282 (11th Cir. 2001), *petition for cert. filed* March 20, 2002

the postulated risk is eventual death, is inconsistent with the measured, scientific foundation upon which medical judgments about risks must be based. A zero-risk standard, if not corrected by this Court, will interfere with critical public health efforts by encouraging health care institutions to expend scarce resources on illusory risks at a time when the country can ill afford to do so. A zero-risk standard does not promote health or safety; to the contrary, it is more likely to increase the risk of the very harms it seeks to prevent.

The *Amici* have expertise in the prevention and control of infectious diseases that threaten the public health. The Infectious Diseases Society of America represents almost 6,000 physicians, scientists, and other health professionals dedicated to excellence in patient care, research, and public health disease prevention and education in the field of infectious diseases. Infectious diseases is a board certified subspecialty of internal medicine and

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(No. 01-1423). *See also Onishea v. Hopper*, 171 F.3d 1289, 1299 (11th Cir. 1999), *cert. denied sub nom. Davis v. Hopper*, 528 U.S. 1114 (2000) ("direct threat" exists whenever there is "evidence that the asserted risk of transmission has a sound theoretical basis," regardless of scientific evidence regarding probability); *Montalvo v. Radcliffe*, 167 F.3d 873, 877-78 (4th Cir. 1999), *cert. denied*, 528 U.S. 813 (1999) (upholding dismissal of HIV-positive student from karate school even though transmission had never occurred in that or a similar setting). In contrast, *see Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) (assessment of "direct threat" requires consideration of the level of risk and the statistical likelihood of occurrence); *Abbott v. Bragdon*, 107 F.3d 934, 948 (1st Cir. 1997), *aff'd in relevant part*, 524 U.S. 624 (1998) (in asserting direct threat defense, "a service provider like Dr. Bragdon is not entitled to demand absolute safety.").

pediatrics. The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America provides a forum for physicians, scientists, and other health care professionals dedicated to the field of HIV/AIDS. HIVMA reflects the variety of medical disciplines engaged in HIV care and research and serves to advance the interests of patients with HIV and to unite providers who work on the front line of the HIV/AIDS epidemic.

The Council of State and Territorial Epidemiologists is a professional association of 400 epidemiologists in all of the states and territories of the United States working together to detect, prevent, and control conditions of public health significance. Its membership includes the official state epidemiologist of every state and territory. Members of the Council are public health scientists on the front lines of the battle against infectious diseases and bioterrorism.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

The lower court's decision is striking because *all* of the expert testimony in the record concluded that the risk that the plaintiff, a dental hygienist with HIV, would transmit the virus to a patient was so low as to be virtually non-existent. The Eleventh Circuit nonetheless held that Mr. Waddell posed a significant risk because there was a *theoretical* risk of transmission that could not be entirely ruled out. This new legal standard, now clearly established in the Eleventh and Fourth Circuit

Courts of Appeals,[4] represents a significant threat to public health. It should be promptly addressed and corrected by this Court.

In *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), and *Bragdon v. Abbott*, 524 U.S. 624 (1998), this Court held that the disability discrimination laws are predicated on a rational approach to assessing health and safety risks based on sound public health principles. A scientific approach to risk assessment is particularly important in disability discrimination law because contagious diseases, like other disabilities, historically have been subject to myths, fears, and stereotypes. *Arline*, 480 U.S. at 284 & n.12 (noting the "complex and often pernicious mythologies about . . . the transmission of illness;" "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness."). At the same time, this Court has been mindful that contagious diseases could pose a health risk to others. In balancing the need to reject exaggerated fears of danger with the goal of avoiding exposing others to real health risks, the Court specified four factors to be weighed[5] and declared that assessments of risk must be

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[4] *See* n.3, *supra*.

[5] Whether an individual with a disability poses a "significant risk" to others requires: "findings of fact, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (*e.g.*, how the disease is transmitted), (b) the duration of the risk (how long the carrier is infectious), (c) the severity of the risk (what is the potential harm to third parties), and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm." *Arline*, 480 U.S. at 274. The ADA's "direct threat" defense codifies this

based on objective medical evidence with deference given to the views of public health authorities. *Bragdon*, 524 U.S. at 650. Indeed, the "direct threat" test first formulated in *Arline* reflects the medical community's scientific approach to assessing the risk of disease transmission. *Arline*, 480 U.S. at 288 (adopting the "direct threat" test from *amicus* American Medical Association).

This sound approach to risk assessment is threatened by the decision below and other recent appellate court rulings interpreting the ADA's "direct threat" provision to require a zero-risk standard. The public health authorities who testified in the instant case unanimously concluded that the plaintiff did not pose a significant risk to his patients and that there was no basis to categorically exclude health care workers with HIV such as Mr. Waddell from practicing their professions. The Eleventh Circuit disregarded their conclusion, not because of a "credible scientific basis for deviating from the accepted norm," *Bragdon*, 524 U.S. at 650, but because of its unlawful zero-risk legal standard. This holding not only aggravates a conflict among the courts of appeals,[6] but also flies in the face of fundamental tenets of public health.

Leading authorities on rational risk assessment have condemned the notion of zero-risk as a completely

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standard. *Bragdon*, 524 U.S. at 649; 42 U.S.C. §§ 12113(b) & 12182(b)(3).

[6] *See Onishea*, 171 F.3d at 1297 (noting conflict among the courts of appeals about "how low the odds may be, and how much evidence it takes to prove a significant risk.").

unworkable basis for establishing law and public policy.[7] As observed by Professor Cass Sunstein, the logic of the zero-risk approach is to respond to even a virtually impossible scenario of grave harm with the question: "Well, it could happen, couldn't it?"[8] Public policy should not, and, indeed, cannot consistently be based on the principle that even a 99.99% assurance of safety is insufficient.[9] Professor Sunstein and others attribute this fallacy to a predictable, but unsound, emotional inclination to misperceive and overreact to particular types of risk.[10] Because a zero-risk standard is impossible to apply consistently, incorporating such a standard into the ADA's "direct threat" test opens the door to precisely the type of

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[7] *E.g.*, Cass R. Sunstein, *The Laws of Fear*, 115 Harv. L. Rev. 1119, 1119-1120, 1123, 1129, 1137 (2002) (reviewing Paul Slovic, THE PERCEPTION OF RISK (2000)).

[8] *Id.* at 1119-1120.

[9] Steven Eisenstat, *The HIV Infected Health Care Worker: The New AIDS Scapegoat*, 44 Rutgers L. Rev. 301, 320 (1992).

[10] Sunstein, *supra* n.7, at 1123, 1129, 1137 ("ordinary people often deal poorly with the topic of risk . . . [based on] "predictable features of human cognition;" "people tend to subscribe to the 'zero-risk' mentality, at least in some domains, apparently believing that it is both possible and appropriate to eliminate risk entirely;" "when strong emotions are at work, people tend to focus on the 'worst case,' in a way that makes the outcome, but not its probability, highly salient"). *See also* Stephen Breyer, BREAKING THE VICIOUS CIRCLE: TOWARD EFFECTIVE RISK REGULATION 35-36 (1993) (setting out the various psychological factors that impede "rational reactions to risk" and observing that "[m]ost people have considerable difficulty understanding the mathematical probabilities involved in assessing risk . . . [and] consistently overestimate small probabilities . . . [and] underestimate large ones.").

discrimination against persons with disabilities, based on irrational fears, that the ADA was intended to prevent. An essential bulwark against this kind of inconsistent, discriminatory approach to assessing risks is the requirement that an assessment of direct threat be based on the statistical likelihood that a feared event will occur. *See Bragdon*, 524 U.S. at 652.

The recent tendency of courts to adopt a zero-risk approach with respect to illusory risks is especially dangerous in the health care context. It is beyond cavil that our society does not have sufficient resources to eliminate entirely even risks that have been demonstrated to result in death.[11] Rules of law that support a lopsided direction of resources toward the elimination of theoretical risks are harmful in at least two ways.

First, such legal decisions undermine efforts of the public health system to marshal resources to address real risks, many of which may emerge suddenly and call for a prompt response. For example, as the Director of the National Institute of Allergies and Infectious Diseases, Dr. Anthony Fauci, wrote recently, the threat of bioterrorism has been transformed from "what was once a theoretical concern . . . [to] a clear and present danger."[12] President Bush has proposed a $1.2 billion increase in bioterrorism funding.[13] The American Hospital

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[11] W. Kip Viscusi, RATIONAL RISK POLICY 97 (1998).

[12] H. Clifford Lane, John La Montagne, and Anthony Fauci, *Bioterrorism: A Clear and Present Danger*, 7 Nature Medicine 1271, 1273 (2001).

[13] *"NIAID Releases Counter-Bioterrorism Research Agenda"* Medical Letter on the CDC & FDA, Apr. 14, 2002, at 2.

Association has distributed new guidelines to 4,900 acute care facilities to "increase hospital readiness" to respond to nuclear, biological, and chemical attacks, including increased disease surveillance capacity, dedicated decontamination facilities, and "staff training at all levels of the organization."[14] In another area, the United States Centers for Disease Control and Prevention (CDC) has warned that new infectious diseases and diseases that are becoming resistant to current treatment, such as multidrug resistant tuberculosis, are a "major threat to U.S. health" and "are swiftly reversing miracles of the previous 50 years."[15] The CDC observed that significantly increased resources are needed to develop new expertise in the diagnosis and treatment of certain diseases rarely seen in this country.[16] Public health authorities and medical institutions in this country will be severely compromised in efforts to meet these and other new threats if legal decisions encourage resources to be directed towards risks that are merely theoretical.

Second, sanctioning discrimination based on a theoretical risk does not increase safety, but in fact may increase risks to others.[17] This case provides one example.

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[14] American Hospital Association, *Hospital Resources for Disaster Readiness* (November 1, 2001) *at* http://www.aha.org/Emergency/Readiness/ReadyAssessmentB1101.asp.

[15] Centers for Disease Control and Prevention, *Preventing Emerging Infectious Diseases: A Strategy For the 21st Century*, 3, 8 (October 1998) *available at* www.cdc.gov/ncidod/emergplan/plan98.pdf.

[16] *Id.* at 39.

[17] It is well established in the field of risk prevention that "[p]aradoxically some of the most well-intentioned efforts to

The development of competent and highly trained health care workers is one of the key components to creating safe conditions for patients. Removing a health care worker whose qualifications are not in dispute based on an illusory risk can result in the replacement of a skilled professional with a less experienced worker, with an actual reduction in the level of care and safety provided to the patient. Moreover, public health is best secured by the early detection, diagnosis and treatment of infectious diseases. This principle ensures that individuals with contagious diseases receive prompt treatment and slows the spread of epidemics by facilitating counseling about how to avoid transmitting the disease to others. As the Court recognized in *Arline*, 480 U.S. at 286 n.15, a rule that permits discrimination based on illusory risks encourages people to hide rather than seeking testing and medical care.

CONCLUSION

As the Court recognized in *Arline*, 480 U.S. at 286 n.15, a rule this Court has played a critical role in ensuring that assessments of health risks in our legal system are based on sound scientific principles. The *Amici* respectfully request that the Court grant the petition for a writ of certiorari in order to clarify that the "direct

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reduce identified risks can turn out to increase other risks." John D. Graham and Jonathan Baert Wiener, *Confronting Risk Tradeoffs*, in RISK VERSUS RISK: TRADEOFFS IN PROTECTING HEALTH AND THE ENVIRONMENT 1 (John D. Graham and Jonathan Baert Wiener eds., 1995).

threat" defense under the ADA should not be analyzed under a zero-risk standard.

Respectfully submitted,

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